STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155234	A. BUILDING 00 B. WING	07/29/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTRIDGE HEALTH CARE CENTER	125 W MARGARET AVE TERRE HAUTE, IN47802

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for a Recertification and State Licensure Survey. Survey dates: July 25, 26, 27, 28, and 29, 2011 Facility number: 000139 Provider number: 155234 AIM number: 100266410 Survey team: Teresa Buske RN-TC Laura Brashear RN Mary Weyls RN Census bed type: SNF/NF: 53 Total: 53 Census payor type: Medicare: 5 Medicaid: 45 Other: 3 Total: 53 Sample: 14 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed 8/4/11 Cathy Emswiller RN	F0000	Submission of this Plan of Correction does not constitute an admission to or n agreement with facts alleged on the survey report. Submission of this Plan of Correction does not constitute an admission or an agreement by the provider of the truth of facts alleged or corrections set forth on the statement of deficiencies. The Plan of Correction is prepared and submitted because of requirements under State and Federal law. Please accept this Plan of Correction as our credible allegation of compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F0164 SS=D	The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. Based on observation and record review, the facility failed to ensure full visual privacy during incontinence care and/or during administration of accucheck/insulin for 2 of 6 residents observed during incontinence care, and during completion of accucheck/administration of insulin in a sample of 14. (Resident # #39, Resident #17)	F0164	F164 The facility feels it has met this requirement through the following corrective measures. Residents #17 and #39 were not harmed. All residents residing within the facility are at risk. The facility presented an in-service on providing privacy during care on 8/8/11. (See attachment "A"). A privacy audit will be conducted to observe five staff randomly. (See	08/19/2011

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	Findings include: 1. On 7/26/11 at 10:35 a.m., Resident # 39 was observed to receive incontinence care by CNA #5. The CNA was observed not to shut the windows blinds while the resident was provided pericare. The window was observed to face a patio utilized by residents and staff. While providing the peri care, CNA #5 was observed to leave the resident without covers the entire time. Once completed, the CNA covered the resident with bed sheet. Review of the clinical record of Resident # 39 on 7/28/11 at 3:40 p.m. indicated the most recent Minimum Data Set (MDS) assessment was completed 5/14/11. The assessment identified the resident with long and short term memory problems. Review of the policy and procedure, titled "Perineal Care" dated 1/06 on 7/29/11 at 11:50 a.m. indicated "Procedure...2. Explain procedure to resident and provide privacy. Drape if needed...." 2. During medication pass observation on 7/26/11 which began at 11:45 a.m., LPN #7 performed a blood sugar test on Resident #17. During the procedure, the door to Resident #17's room was left		attachment “B”) The audit will be completed weekly for 4 weeks, monthly for 2 months, and then quarterly thereafter. The findings of these audits will be reviewed during the facility’s quarterly Quality Assurance meeting and the plan of action adjusted accordingly. The above corrective actions will be completed on or before 8/19/11.	

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	open. Resident # 18 and housekeeper # 14 were in the hallway directly outside Resident #17's room. After performing the blood sugar test the nurse gave Resident #17, an insulin injection. During the injection, housekeeper #14 entered the resident's room. Review of the facility's current policy and procedure titled, "Blood Glucose Monitoring Procedure" dated 9/05 on 7/29/11 at 11:55 a.m. indicated the following: " ...Procedure...Explain procedure and provide privacy..." 3.1-3(p)(2) 3.1-3(p)(4)			
F0246 SS=D	A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. Based on observation, record review and interview the facility failed to a system in which the resident could summon help for 1 of 1 resident reviewed, unable to summons staff in a sample of 14 in that the resident was unable to operate the current call light due to physical condition. (Resident #13)	F0246	F246 The facility will ensure this requirement through the following corrective measures. Resident #13 was not harmed. All impaired residents within the facility may be at risk. The facility assessed all residents within the building and found that resident # 22 and resident # 24 may also benefit from a touch call	08/19/2011

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	Findings include; During initial tour on 7/25/11, which began at 7:20 a.m., with LPN #7, the LPN indicated Resident #13 was a quadriplegia. A call light was observed laying in the bed, beside the resident. The LPN indicated the resident was able to utilize the call light. On 7/26/11 at 10 a.m., Resident #13 was in bed. The call light was observed to be on the bed beside the resident. During interview of CNA #10, on 7/26/11 at 10 a.m., the CNA indicated the resident was not able to utilize the call light, indicating "Her hands are not able to push the button on the call light." The CNA indicated "they are thinking about getting her a pressure call light." The CNA indicated the resident's cognition varied from day to day, and at times had confusion. During interview of the resident on 7/27/11 at 11:30 a.m., the resident indicated she was unable to utilize the call light, but indicated the staff check on her routinely. Resident #13's clinical record was reviewed on 7/27/11 at 10:30 a.m.		light. (See Attachment “C”) The touch call lights have been ordered for the above 2 residents. (See Attachment “D”) Residents will be assessed, upon admission, to determine the need for an adaptive call light. The findings of the assessments will be reviewed 5 times a week during the morning IDT/Department Head Meeting. The roster of residents will also be reviewed quarterly in the Quality Assurance Meeting to determine any further adaptations. The above corrective actions will be completed on or before 8/19/11.	

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	An admission date, was noted, of 3/3/11. A diagnosis was noted of, but not limited to, Brain tumor with right sided hemiparesis. The most recent quarterly Minimum Data Set (MDS) assessment, dated 6/18/11, indicated the resident was unable to be interviewed. A procedure titled "CALL LIGHT PROCEDURE" provided by the DON (Director of Nursing) on 7/29/11 at 12 noon, indicated a functioning call light was provided to allow resident to request assistance when needed. 3.1-3(v)(1)			
F0315 SS=D	Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. Based on observation and record review the facility failed to maintain indwelling Foley catheters in a manner to prevent potential infection for 2 of 2 residents with Foley catheters reviewed in a sample	F0315	F315 The facility will ensure this requirement is met through the following corrective measures. Residents #24 and #34 were not harmed. All residents within the facility who untilize a catheter may be at risk.	08/19/2011

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	of 14 in that the catheters were not secured to prevent tension on the urethra and were in contact with the floor, and insertion site cleansed with soiled gloves. [Residents #24 and #34] Findings include: 1. During initial tour on 7/25/11 at 7:00 a.m. with LPN # 12 Resident #24 was observed in bed with a Foley catheter. On 7/26/11 at 9:10 a.m. Resident #24 was observed in bed and for the catheter tubing to be stretched taught and not secured to prevent tension. On 7/28/11 at 4:30 p.m. the resident was observed in bed, and the catheter tubing was observed to be in contact with the floor. On 7/27/11 at 2:00 p.m. with CNA #3 the resident was observed in bed and the catheter tubing was observed not to be secured to prevent tension. Resident #24's clinical record was reviewed on 7/26/11 at 10:10 a.m. A Minimum Data Set [MDS] assessment, completed on 5/2/11 coded the resident as utilizing a Foley catheter. The assessment coded the resident as requiring extensive assistance of two for bed mobility and		All residents utilizing catheters were assessed for signs and symptoms of Urinary Tract Infections. All residents with catheters have the leg straps to reduce tension. All staff are being inserviced on Foley Catheter Care. (SeeAttachment E) The Director of Nursing or Designee will monitor catheter placement and catheter care on all residents with catheters. (See Attachment F) This will be done 5x/weekly x 4 weeks, then weekly x 4 weeks, then monthly x 2 months and quarterly thereafter. The findings of these audits will be reviewed during the facility's quarterly Quality Assurance meeting and the plan of action adjusted accordingly. The above corrective acions will be completed on or before 8/19/11.	

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	transfers. Physician's orders were noted dated 5/8/11 and 6/4/11 for antibiotics for treatment of urinary tract infections. A plan of care with most recent date of 4/24/11 addressed the problem of resident requires use of Foley catheter due to urinary retention and at risk for infection. Interventions included, but were not limited to, Position catheter tubing and drainage bag in such a way as to avoid contact with the floor. 2. During initial tour on 7/25/11 at 7:00 a.m. with LPN #12 Resident #34 was observed in bed with an indwelling Foley catheter. On 7/26/11 at 9:10 a.m. CNA #2 and #3 were observed to provide incontinence care to the resident. The resident was observed to have been incontinent of stool. While wearing gloves CNA #2 was observed to cleanse the resident's buttocks. While wearing the same gloves the CNA cleansed the resident's perineal area and catheter tubing. The catheter was observed not to be secured to prevent tension to the meatus and to be taught while repositioning the resident during the care. Resident #34's clinical record was reviewed on 7/25/11 at 1:45 p.m. An			

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	admission date was noted of 7/8/11. A "Catheter Assessment" dated 7/21/11 included documentation of the catheter being utilized for comfort and urinary retention. A plan of care which addressed the catheter was lacking on 7/25/11 at 1:45 p.m. A facility policy titled "Foley Catheter Maintenance Procedure," dated 9/05, provided by the Administrator on 7/29/11 at 11:55 a.m. included, but was not limited to: "Placement of Catheter Tubing 1. When in bed or wheel chair: a) Position tubing with no tension, ...c) Ensure bag or tubing is not touching floor. ...Catheter Care ...1. Apply gloves after washing hands. 2. Clean the tubing with soap and water starting at the urethral opening and cleansing downward away from the opening. ...4. Complete the rest of the perineal care, cleansing with soap and water from front to back following the perineal care policy. 5. Remove gloves and wash hands." 3.1-41(a)(2)			

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F0371 SS=F	The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, record review and interview, the facility failed to ensure 1. food items were held at the proper temperature, and 2. dry food items were maintain in a sealed container. This had the potential to affect 49 of 52 residents receiving oral intake. Findings include: On 7/25/11 at 7 a.m., during Kitchen/Food service observation, steam table temperatures were measured. The sausage patties temperature measured 120 degrees Fahrenheit and the pureed scrambled eggs measured 130 degrees. A plastic container storing flour, was noted with a large crack across the lid. A plastic container storing oatmeal, was noted with a space between the lid and the base. Review of the facility policy titled "FOOD TEMPERATURES" provided by the Food Service Supervisor (FSS) on 7/29/11 at 12 noon, documentation indicated "Foods will be served at proper	F0371	F371 The facility will ensure this requirement is met through the following corrective measures: 1. All areas of concern have been corrected. 2. All residents have the potential to be affected. The Registered Dietitian Consultant in-serviced on cooking, holding and reheating temperatures of food and on Food Storage on 8/9/11. A policy review on serving and reheating temperatures was conducted. The policy on "Food Temperaturees on Service Line" was updated and examined (See Attachment G). The policy on "Reheating Temperatures was discussed with no changes made (See Attachment H). 3. The temperature knob on the steam table was noted to be broken and a replacement knob was delivered on 8/3/2011. Dietary staff are recording food temperatures at all three meals and reheating or discarding food that does not meet minimum temperature requirements. Failure to comply with recording food temperatures and/or taking corrective action as necessary when food does not meet minimum temperature requirements will result in disciplinary measures. The dietary manager or designee will audit the	08/19/2011

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	temperature to ensure food safety". The policy indicated hot foods should be maintained at or above 135 degrees Fahrenheit. During interview of the FSS, on 7/29/11 at 12 noon, the FSS indicated the facility did not have a policy concerning dry food storage. The FSS indicated dry food should be stored in a container which prevents possible contamination. 3.1-21(i)(2) 3.1-21(i)(3)		steam table temperatures for five times per week, alternating between breakfast, lunch, and supper for 4 weeks, then three times per week for 4 weeks, then monthly for 3 months, then quarterly until compliance is maintained (See Attachment I) 4. The flour did not have any visible signs of contamination. The broken lid was discarded and plastic wrap was tightly sealed over the bin. A new ingredient bin was ordered and arrived on 8/1/2011. The current policy entitled, “Sanitizing Ingredient Bins” was updated to include the use of tight fitting lids that are in good condition. The Registered Dietitian reviewed the updated policy with all dietary staff members on 8/9/11 (See Attachment J). The Dietary Manager or designee will audit the ingredient bins 5 times weekly, then three times weekly for 4 weeks, then monthly for three months, then quarterly until compliance is maintained. (See Attachment I). 5. The above corrective actions will be completed by 8/19/11.	

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F0441 SS=E	The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.			
	Based on observation, and record review the facility failed to ensure hand hygiene was maintained to prevent contamination by : 1) 2 of 5 licensed nurses observed providing care i.e. nasogastric tube care	F0441	F441 The facility will ensure this requirement is met through the following corrective measures:1. Residents #28, #34, and #39 were not harmed.2. All resident have the potential to be	08/19/2011

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	for 2 of 2 residents observed receiving nasogastric care by licensed nurses in a sample of 14 (Resident #39, Resident # 28) and 2) 2 of 6 CNAs observed providing incontinence care for 2 of 6 residents observed incontinent in sample of 14 (Resident # 39, Resident #34) . [CNA # 2, CNA # 5, LPN #13, LPN #1] Findings include: 1. Resident #39 was observed to be incontinent of urine on 7/26/11 at 10:35 a.m. CNA #5 was observed to provide incontinence care. The CNA with gloves on provided peri care and with the same gloves cleansed the resident's buttocks. Without changing the contaminated gloves, the CNA was observed to adjust side rails, position pillows under legs, open bathroom door, comb the resident's hair, move clean linens to chair in room, place overbed table next to bed, and adjust the room air temperature. The CNA then removed the contaminated gloves and wash her hands. 2. On 7/28/11 at 2:05 p.m., LPN #13 was observed administer medications through Resident #39's gastrostomy tube. The LPN was observed to wear gloves. After administering the medications via the gastrostomy tube, LPN #13 without changing the contaminated gloves was		affected.3. The facility held an inservice on “Handwashing, Enteral Medication Administration, Use of Gloves, and Peri-Care. (See Attachment K). Checkoffs will be completed for staff on the above procedures. Five staff members will be monitored 5 times weekly for 4 weeks, then one time weekly for 4 weeks, and then quarterly thereafter to ensure continued compliance (See Attachment L)4. The findings of these audits will be reviewed during the facility’s quarterly Quality Assurance Meeting and the plan of action adjusted accordingly.5. The above corrective actions will be completed by 8/19/11.	

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	observed to open the bathroom door and to rinse the syringe utilized to administer the medications. The LPN was then observed to remove the contaminated gloves and to wash hands. 3. On 7/26/11 at 9:10 a.m. CNA #2 and #3 were observed to provide incontinence care to Resident #34. The resident was observed to have been incontinent of stool. While wearing gloves CNA #2 was observed to cleanse the resident's buttocks. While wearing the same gloves the CNA cleansed the resident's perineal area and catheter tubing. The CNA after cleansing stool from the resident with the same gloves on assisted the resident to turn in bed, held the resident's hands, adjusted the linens, washed the resident's eyes and face, picked up clean gown handled the wash basin cleansed the residents groin, incision site. The CNA opened the resident's bedside table with the gloves on, and was instructed by CNA #3 to remove the gloves. 4. On 7/26/11 at 11:15 p.m., LPN #1 was observed to administer medications to Resident #28 through a gastrostomy tube. While wearing gloves, the LPN handled the tube, attached a syringe to the tube, administered water flushes and medications, and recapped the tube. With			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155234	A. BUILDING 00 B. WING	07/29/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTRIDGE HEALTH CARE CENTER	125 W MARGARET AVE TERRE HAUTE, IN47802

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	the same gloves on the LPN opened the bathroom door, turned on the faucet and rinsed the syringe and returned it to a plastic bag in the resident's room before removing the gloves. Review of "Complete Bed Bath Procedure" [no date] on 7/29/11 at 12:40 p.m. indicated the following: "Apply gloves; Wash, rinse, and dry from neck to buttocks, including anal area; Change bath water and gloves, using clean wash cloth and towel provide perineal care according to procedure; remove gloves; dress or assist with dressing appropriately; make resident comfortable..." Review of "Enteral Med Administration Procedure" [no date] on 7/29/11 at 12:40 p.m. indicated the following: " ...Wash hands and apply gloves;...check tube placement; Flush tube with 30 ml water prior to giving any meds;... Flush after last med with 30 ml water;... Remove gloves and turn pump back on..." 3.1-18(l)			